

S. No. 2  
M-5-42  
5-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 18232

FILED JUN 8 1943

Registration District No. \_\_\_\_\_

Primary Registration District No. 3034

Registrar's No. 45

1. PLACE OF DEATH:

(a) County Jay

(b) City or town Higginsville  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jay

(c) City or town Higginsville  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mathilda Klein

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22  
year 1943 hour 6 minute A.M.

21. I hereby certify that I attended the deceased from May 12, 1943, to May 22, 1943 that I last saw her alive on May 22, 1943 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

6. (a) Name of husband John Keleny 6. (b) Single, widowed, married, divorced Married

6. (c) Age of husband 72 if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 30 1876  
(Month) (Day) (Year)

Immediate cause of death Arteriosclerosis

Due to Cerebral hemorrhage

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE: Years 66 Months 7 Days 27 hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Cole Camp Mo  
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

Underline the cause to which death should be charged statistically.

10. Usual occupation Housekeeper

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Henny Feldmann

13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

14. Maiden name Matha Wagnke

15. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Charles E. Clark (M. D. or other) M.D.  
Address Higginsville Mo Date signed 5/22/43

16. (a) Informant John Klein

(b) Address Higginsville Mo

17. (a) Burial (b) Date thereof May 24 43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Higginsville Mo

18. (a) Signature of funeral director W.A. Braeklein

(b) Address Higginsville Mo

19. (a) 5-24-1943 (b) Dr. W.A. Braeklein  
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number .....

Date Filed 6-2-43

FEB 23 1945

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Roy F Wiegman

Licensed Embalmer No. 2883

P. O. Address Higginsville Md

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.